Intensive Chronic Case Management (ICCM)

A project to provide intensive RN case management with a focus on the integration of acute and long-term care services to high-cost Medicaid clients.

June 14, 2006 LTC Task Force

Project Information

- ICCM was provided in two Area Agencies on Aging:
  - Pierce County Aging and Long Term Care
  - Southeast Washington Aging and Long Term Care
- Project contact: Candace (Candy) Goehring (goehrcs@dshs.wa.gov) or Dan Murphy (murphdk@dshs.wa.gov)
- Project study period was April 2004 through March 2006.

Project Overview

- The focus of the ICCM was to:
  - Lower Medicaid expenditures by providing RN case management to integrate acute and LTC services through assessment and interventions that promote healthy outcomes and reduces medical interactions as well as risk to the client.
  - 3 way relationship: client, their practitioner and DSHS.
  - Goals: Maintain health status, minimize acute episodes, limit disability and reduce costs.
  - Baseline year medical costs per client of >$10,000,

How the ICCM project works

- Provides enhancement of case management interventions:
  - Case worker with a mandate to manage the individual's care across service systems;
  - Time and access to information to be able to do that; and
  - Measures results of interventions.
- Combines medical and LTC services into a care plan that addresses the client's needs in an integrated manner.

How the ICCM project works

- Based on Chasm Report aims; effective, safe, timely, efficient and client centered
- Implements preventive care measures to delay the decline and promote abilities.
- Improve cost effectiveness and utilization to achieve individual client outcomes.
- Client identified individual health goals.

Critical Project Model Elements

- **RN assessment and case management;**
- **Measurement of health outcomes and resource utilization pre and post interventions;**
- **Implement when possible evidence based practice;**
- **Integrate services cross administration.**
- **Improve coordination of primary, acute and long-term care.**
- **Enable clients and their caregivers access to a medical home through community partnerships (vendors, pharmacies, centers for independence, mental health counseling);**
- **Facilitate the use of data warehouses and IT to speed care and provide quality interventions;**

Key Implementation Elements

- Adult, Medicaid only clients already receiving less intense LTC case managed by the Area Agency on Aging;
- Baseline year medical costs over $10,000;
- Medicaid clients not receiving case management, but not in a SNF;
- Disabled from trauma or illness and vulnerable to the long term effects of immobility; and
- Quadriplegia, paraplegia, MS, ALS, Parkinson's, morbid obesity.

Client identification

- Initial clients enrolled in the project were identified by the AAA, as well as using MMIS data to find eligible client not receiving case management;
- 106 clients enrolled in two years;
- 62 clients active in the project;
- Average age 45;
- Client disenrollment reasons; death, incarceration, moved, no longer Medicaid eligible, declined to participate.

Partners and Roles

- Aging and Disability Services Administration: Project management and data collection.
- Area Agencies on Aging: RN Intensive Case Management of clients.
- Health and Recovery Services Administration: data collection for control group, case collaboration and coordination, facilitation of “rule-bending”.

Project Evaluation

- First four quarters demonstrated a return on investment of 3:1.
- 10 clients enrolled in Medicare.
- Number of health system interactions per client/per year reduced 18 % (187 to 153).
- Other reductions in utilization:
  - **ER 9%**
  - **Home Health visits 60%**
  - **Hospital days 15%**
  - **Prescriptions 19%**
  - **Physician office visits 22%**

Theme: Multi-dimensional

- Clients referred for chemical dependency treatment, domestic violence, sexual assault counseling;
- Coordination with HRSA for DME authorizations to increase mobility and independence;
- Coordination with community pharmacies/MD to identify duplicate therapies.
- Increased client contact with their medical provider.
- Coordination with SNF staff preparing for D/C to the community and supporting clients in their decision making;
- Clients returned to school and vocational training;
- Coordination with HRSA for in-patient stays to offset LTC costs and increase client independence long term;
- Referrals to dental care programs for poor dentition impacting nutrition, infections, and ability to participate in school or vocational programs.

Theme: Care organized around the consumer

- ICCM recognizes the comprehensive nature of the client assessment and service planning need. Not program or provider focused;
  - Clients participated while at home, in Skilled Nursing Facilities or Adult Family Homes;
  - Clients/RN engaged with:
    - Pharmacies, school, work, inpatient and outpatient providers, adaptive aid providers (including heaing aids), dental care/oral hygiene, CD and mental health counseling

Theme: Progressive Nature of Chronic Care

- RN Case Manager is constant presence for the client regardless of provider or service;
- Not single disease focused;
- Emphasis on the co-morbid diseases and events; infections, pain, depression, mental illness, skin breakdown, effects of immobility, adaptive aids;
- Client identified health goals to achieve independence.

Theme: Disabling Aspects (Total $$)

Diagnosis	$ Control Group **N= 98**	$ ICCM group **N= 102**
Chronic ulcer	$ 101,659.03	$ 47,654.74
Decubitus Ulcer	$ 1,172,099.51	$ 158,514.76
Infection / urinary catheter	$ 81,938.94	$ 0.00
Multiple Sclerosis	$ 1,207,660.63	$ 188,241.89
Pneumonia, unspecified organism	$ 149,819.56	$ 33,126.35
Pneumonitis (aspiration)	$ 163,543.30	$ 34,975.87
Urinary tract infection	$ 260,951.99	$ 191,756.59
Dehydration	$ 60,248.77	$ 17,640.27

Theme: Self determination and management

- Several national references including the IOM Chasm Report were used in the design of the ICCM model of care implemented in 2004:
  - Community based
  - Promotes consumer self-determination, including recognition of health problems and social determinants;
  - Integration of medical, mental health and supportive service links; and
  - Developing a health care model designed specifically to meet the needs of the vulnerable with quality measures.

    (CDC, Don Berwick, IOM Chasm Report, CHCS, The Presidents Commission on Consumer Protection and Quality in the Health Care Industry, Secretary Braddock (WA DSHS)).

Theme: Engaging Family/Informal Supports

- The ADSA model of case management includes assessment of family and other informal supports in determining level of services, and supports provided by family and caregivers.
- The ICCM model of RN Intensive Case Management includes incorporation and recognition of the family, informal supports as well as the environment.